

**LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
PAYER FINANCIAL INFORMATION**

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

CLIENT INFORMATION

1 CLIENT NAME	SS #	DMH CLIENT ID #
2 MAIDEN NAME	DOB	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP
SPOUSE NAME		

THIRD PARTY INFORMATION

3 NO THIRD PARTY PAYER <input type="checkbox"/>							
4 MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDI-CAL COUNTY CODE / AID CODE / CIN #		MEDI-CAL PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO REFERRED FOR ELIGIBILITY ASSESSMENT <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE REFERRED	
5 SHARE OF COST <input type="checkbox"/> YES <input type="checkbox"/> NO		SOC AMT \$		SSI PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO		SSI APPLICATION DATE	
IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON							
6 CALWORKS <input type="checkbox"/> YES <input type="checkbox"/> NO		GROW <input type="checkbox"/> YES <input type="checkbox"/> NO		HEALTHY FAMILIES <input type="checkbox"/> YES <input type="checkbox"/> NO		HEALTHY FAMILIES CIN #	
AB3632 <input type="checkbox"/> YES <input type="checkbox"/> NO		AB3632 CONSENT FORM SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO					
7 MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDICARE #		LIFETIME AUTHORIZATION SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDI-GAP <input type="checkbox"/> YES <input type="checkbox"/> NO	
VET/ADM <input type="checkbox"/> YES <input type="checkbox"/> NO		CHAMPUS <input type="checkbox"/> YES <input type="checkbox"/> NO		HEALTHY WAY LA <input type="checkbox"/> YES <input type="checkbox"/> NO		HWLA MEMBER #	
8 HMO/PPO <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF CARRIER			GROUP/POLICY/ID #		NAME OF INSURED
9 CARRIER ADDRESS						ASSIGNMENT / RELEASE OF INFORMATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	

PAYER REFERENCES (CLIENT OR RESPONSIBLE PERSON)

10 NAME OF PAYER		RELATION TO CLIENT		DOB		MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP		PAYER CDL/CAL ID	
11 ADDRESS		CITY		STATE		ZIP CODE		TEL #	
12 SOURCE OF INCOME: <input type="checkbox"/> SALARY <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> UNEMPLOYMENT INSURANCE <input type="checkbox"/> DISABILITY INSURANCE <input type="checkbox"/> SSI <input type="checkbox"/> GR <input type="checkbox"/> VA <input type="checkbox"/> Other Public Assistance <input type="checkbox"/> IN-KIND <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER: _____								PAYER SS #	
13 EMPLOYER				POSITION				IF NOT EMPLOYED, DATE LAST WORKED	
14 EMPLOYER'S ADDRESS (Include City, State & Zip Code)								TEL #	
15 SPOUSE		ADDRESS (Include City, State & Zip Code)						SPOUSE'S SS #	
16 SPOUSE'S EMPLOYER				POSITION				IF NOT EMPLOYED, DATE LAST WORKED	
17 SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code)								TEL #	
18 NEAREST RELATIVE/RELATIONSHIP		ADDRESS (Include City, State & Zip Code)						TEL #	

UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS		20 ALLOWABLE EXPENSES		21 ADJUSTED MONTHLY INCOME	
Savings \$ _____		Court ordered obligations paid monthly \$ _____		Gross Monthly Family Income	
Checking Accounts \$ _____		Monthly child care payments (necessary for employment) \$ _____		Self/Payer \$ _____	
IRA, CD, Market value of stocks, bonds and mutual funds \$ _____		Monthly dependent support payments \$ _____		Spouse \$ _____	
TOTAL LIQUID ASSETS \$ _____		Monthly medical expense payments \$ _____		Other \$ _____	
Less Asset Allowance \$ _____		Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) \$ _____		TOTAL HOUSEHOLD INCOME \$ _____	
Net Asset Valuation \$ _____		Total Allowable Expenses \$ _____		TOTAL FROM BOX 19 \$ _____ +	
Monthly Asset Valuation (Divide Net Asset by 12) \$ _____		VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO		SUBTOTAL \$ _____	
VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO		VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO		LESS TOTAL FROM BOX 20 \$ _____ -	
Number Dependent on Adjusted Monthly Income (Client included)		ANNUAL LIABILITY		Adjusted Monthly Income \$ _____	
22		FROM TO		VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	
23 PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)		ANNUAL CHARGE PERIOD		Payment Plan \$ _____ per month for <u>1 2 3 4 5 6</u> months.	

OTHER

24 PRIOR MENTAL HEALTH TREATMENT DURING THE CURRENT ANNUAL CHARGE PERIOD <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE:		FROM TO		PRESENT ANNUAL LIABILITY BALANCE	
25 ANNUAL LIABILITY ADJUSTED BY		DATE		REASON ADJUSTED	
ANNUAL LIABILITY ADJUSTMENT APPROVED BY		DATE		PROVIDER NAME AND NUMBER	
26 An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER				PROVIDER NAME AND NUMBER	
27 I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON					
DATE					